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## Workforce Innovation & Opportunity ACT

### **Authorization to Disclose and Release Information**

I, \_\_\_\_\_ DOB \_\_\_\_\_, do hereby consent to authorize the release of information from any of the following sources to Oneida WIOA Program.

<input type="checkbox"/> Oneida Central Accounting	<input type="checkbox"/> Oneida Human Resources
<input type="checkbox"/> Oneida Economic Support	<input type="checkbox"/> Oneida Social Services
<input type="checkbox"/> Oneida Enrollment Office	<input type="checkbox"/> Oneida Higher Education
<input type="checkbox"/> Oneida Vocational Rehabilitation	<input type="checkbox"/> Enrollment Office(s)
<input type="checkbox"/> Other: _____	

This Release of Information authorizes disclosure and discussion of agency records or case notes of above-named individual for the purposes of:

<input type="checkbox"/> Eligibility Determination	<input type="checkbox"/> Individual Plan for Employment
<input type="checkbox"/> Case Management	<input type="checkbox"/> Other: _____

I understand that I may rescind this authorization at any time by notifying the Oneida WIOA Program in writing. I understand that any information collected will be kept confidential.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_